

1142

1124

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived before admission) a. STATE <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		b. COUNTY <b>Talbot</b>	
c. LENGTH OF STAY IN Tb. <b>22 hrs 40 min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, "Doncaster"</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hosp.</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Madge</b> Middle <b>S.W.</b> Last <b>Anthony</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 21, 1887</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR: Months <b>4</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper Donhome</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	
11. BIRTHPLACE (State or foreign country) <b>Talbot Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Franklin J. C. Conington</b>		14. MOTHER'S MAIDEN NAME <b>Anne R. Devosy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>J. Huggins Henry J. Easton MD</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic coronary thrombosis</b> DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 29 1961</b> to <b>Jan 29 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 29 1961</b> , and that death occurred at <b>2:20 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thorston Harrison</b>		22b. DATE SIGNED <b>29 Jan 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THORSTON HARRISON</b>		22d. ADDRESS <b>Chevy Chase, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 31, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Easton MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Frank</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 1 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

(S)

W. K.  
MILITARY  
OFFICE

1143

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Lalbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Lalbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lippe</u>		c. LENGTH OF STAY IN: 1b <u>Culture Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Norman</u> First <u>S.</u> Middle <u>Baker</u> Last		4. DATE OF DEATH Jan. 31 1961	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Franklin A. Baker</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Russ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-22-7759</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept</u> 19 <u>1955</u> to <u>31</u> 19 <u>1961</u> , that I last saw the deceased alive on <u>1-31</u> 19 <u>1961</u> , and that death occurred at <u>6-30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William L. Winters</u>		ADDRESS (Street, city or town, state) <u>210 E. DOVER, EASTON MD 21828</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM L. WINTERS</u>		DATE SIGNED <u>2/3/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 3, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Easton, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam &amp; Son</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 7 '61</u>	
ADDRESS <u>Easton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION  
PUBLISHED WEEKLY  
CHICAGO, ILL., U.S.A.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1131

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TRAPPE rural</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Trappe rural</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)							
3. NAME OF DECEASED (Type or print) First <b>Bob</b> Middle <b>Bantum</b> Last <b>Bantum</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-93?</b>	9. AGE (In years last birthday) <b>67?</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farmecannery</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-16-1773</b>		17. INFORMANT <b>Daisy Roberts Trappe md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage - recurrent</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF DEATH Hour <b>7</b> p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Lewis Orshy</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>WELTY</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>1-16-61</b>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-18-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trappe Cem</b>		22d. LOCATION (City, town, or country) (State) <b>Trappe md.</b>	
23. FUNERAL DIRECTOR <b>James D. Doherty, Porters, md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>JAN 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	





may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1145

64132

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Easton Md</u>				c. LENGTH OF STAY IN 1b <u>75 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles William Bowman</u>				4. DATE OF DEATH <u>Jan 21 1961</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1901</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Bowman Jr</u>				14. MOTHER'S MAIDEN NAME <u>Relia C. Jacobs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unit; if no, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-38-0964</u>		17. INFORMANT <u>Mrs C. E. Bowman</u> Address <u>Easton Md. R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 1961</u> to <u>2/2 1961</u> , that (I) (we) last saw the deceased alive on <u>19/2 1961</u> , and that death occurred at <u>P. M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Horston Harrison</u>				22b. DATE SIGNED <u>23/2 61</u>			
22c. PHYSICIAN'S NAME (Type) <u>HORSTON HARRISON</u>				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Jan 23 61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Crematory</u>		23d. LOCATION (City, town, or county) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. ...</u>				25a. REC'D BY REGISTRAR <u>...</u>		25b. REGISTRAR'S SIGNATURE <u>...</u>	
				DATE <u>JAN 25 '61</u>			

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UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A11 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>2 hours</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton (Rural)</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Easton, Maryland</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Katherine Buchanan</u> First Middle Last		4. DATE OF DEATH <u>January 7 1961</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28, 1895</u> AGE (In years last birthday) <u>65</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. George Baetjer</u>		14. MOTHER'S MAIDEN NAME <u>Edith Mae Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-4771</u>	
17. INFORMANT <u>Rev. Daniel Buchanan</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>No</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred on <u>Jan 7</u> , 1961, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JAN. 9, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Park near Easton, Maryland</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman &amp; Son</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Kline</u>	

STATE OF NEW YORK  
JANUARY 10, 1900  
JANUARY 10, 1900

1899

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

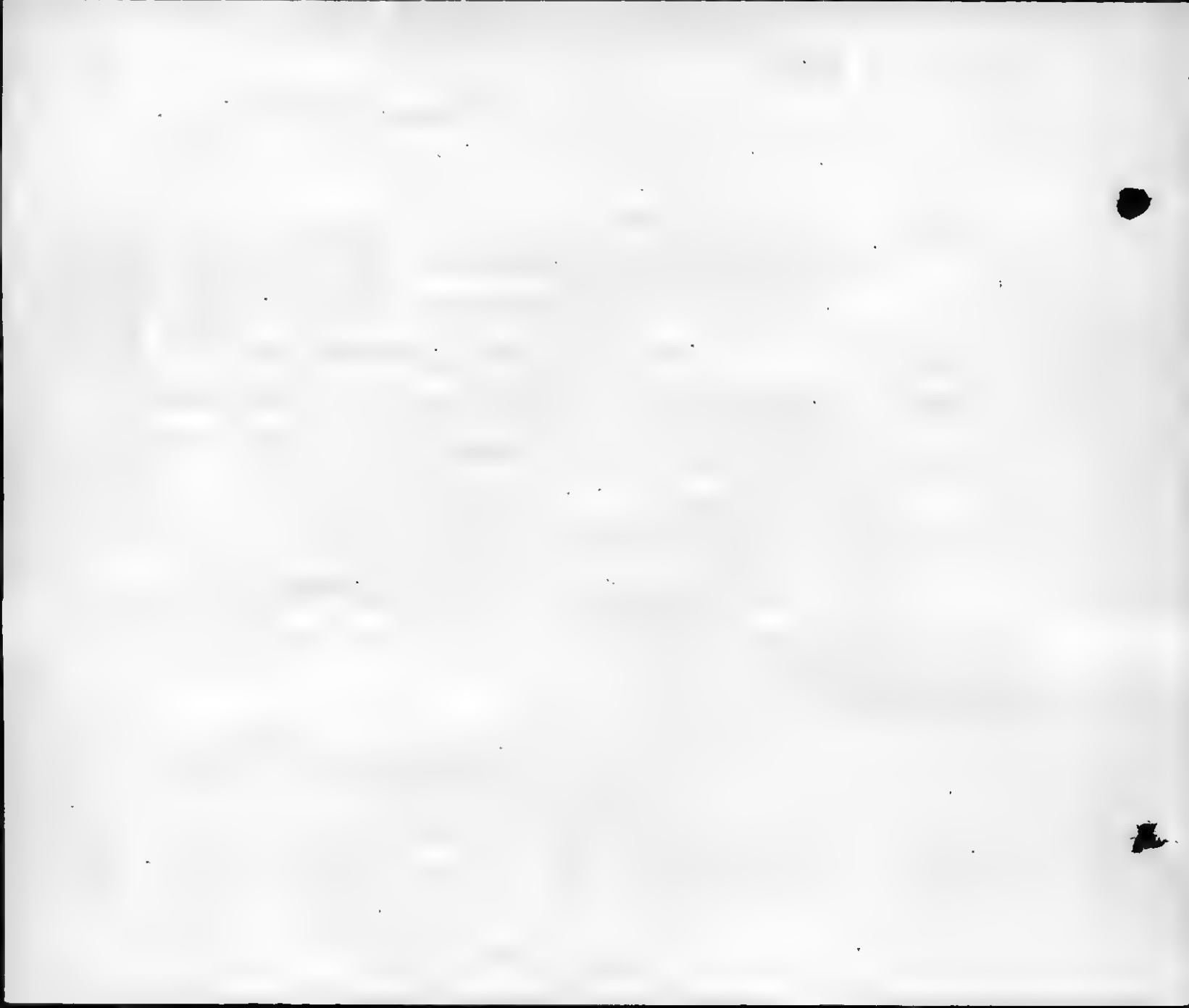
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CERTIFICATE OF DEATH

61134

1. PLACE OF DEATH a. COUNTY <u>Pulbert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pulbert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>St. Michaels</u>			
3. NAME OF DECEASED (Type or print) <u>Walter R. Burns</u>				4. DATE OF DEATH Month <u>1</u> - Day <u>30</u> - Year <u>1961</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1883</u>	9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>St. Michaels Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Orlando H. Burns.</u>				14. MOTHER'S MAIDEN NAME <u>Leatrice Eckhardt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>220-170555</u>		17. INFORMANT Address <u>Ida Burns St. Michaels Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>atherosclerosis, severe aortic regurgitation, and</u> DUE TO <u>hypertension and tuberculosis</u> (c) <u>hypertension and tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7:10</u> <u>1961</u> to <u>1:30</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>5:30</u> <u>1961</u> and that death occurred at <u>3</u> <u>PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Walter R. Burns</u> M.D.				22b. DATE SIGNED <u>1-31-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Walter R. Burns M.D.</u>				22d. ADDRESS <u>St. Michaels Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-3-61</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Clivet</u>		23d. LOCATION (City, town, or county) (State) <u>St. Michaels Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Kraus</u> ADDRESS <u>Peghmen Md.</u>				25a. REC'D BY REGISTRAR <u>Feb 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Orlando H. Burns</u>	



1  
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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

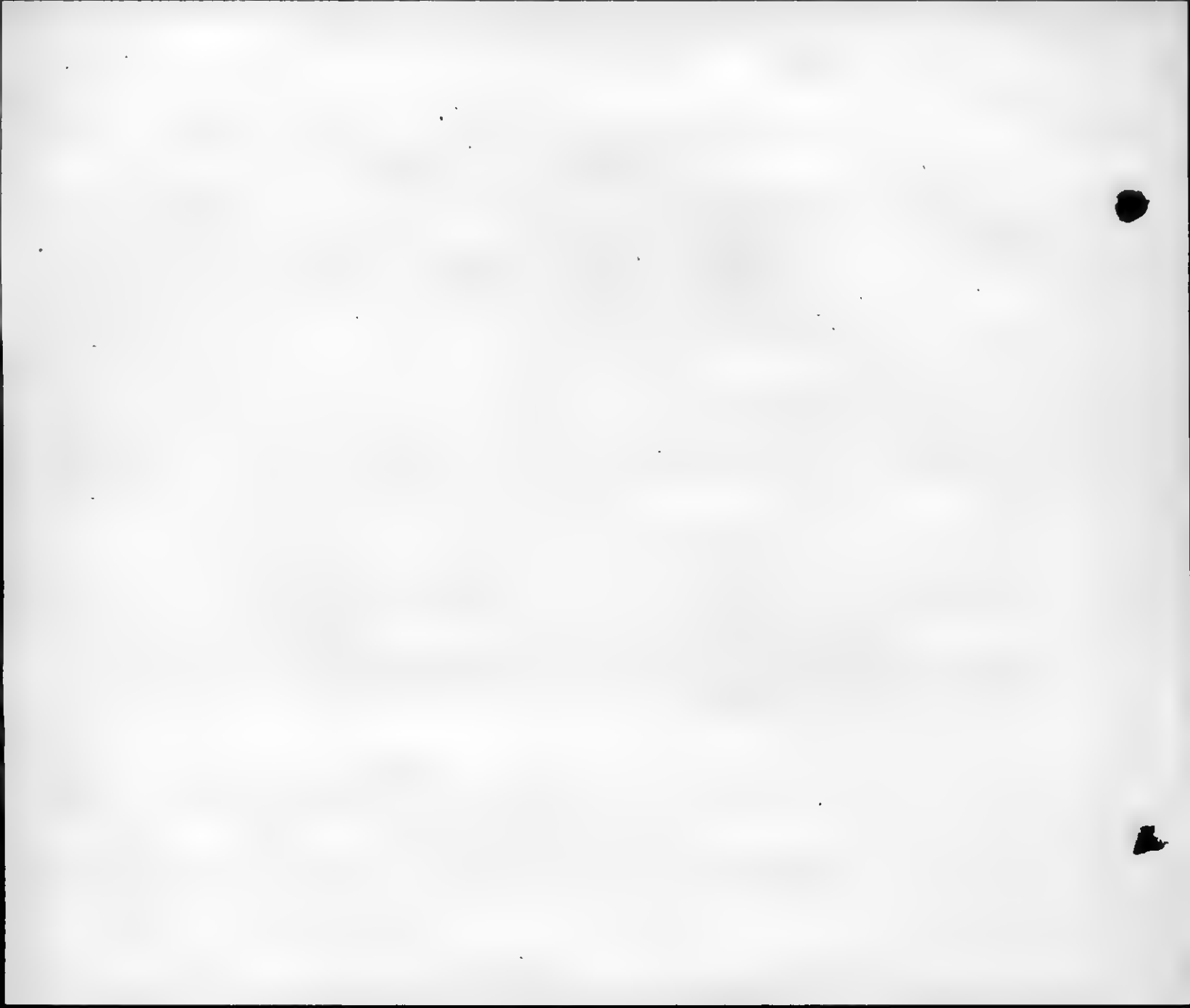
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1148

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

61155

1 PLACE OF DEATH a. COUNTY <b>Talbot</b> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>EASTON</b> c. LENGTH OF STAY IN 1b <b>34 hrs 5 mins</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Hill</b> d. STREET ADDRESS <b>1772</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH HENRY BUTLER</b>		4. DATE OF DEATH Month Day Year <b>1 - 30 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1889</b>
9. AGE (In years lost birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Queen Anne Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Butler</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Harris</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-03-0390</b>	
17. INFORMANT <b>Coro Butler, Church Hill, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>A.H.D</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that death occurred at <b>2:30</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>R. C. Cox</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/3/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Church Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Church Hill, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert M. Cox</b>		25a. REC'D BY REGISTRAR <b>FEB 3 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Artur S. Evans</b>		25c. ADDRESS <b>Cambridge, Md</b>	





# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. It is designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

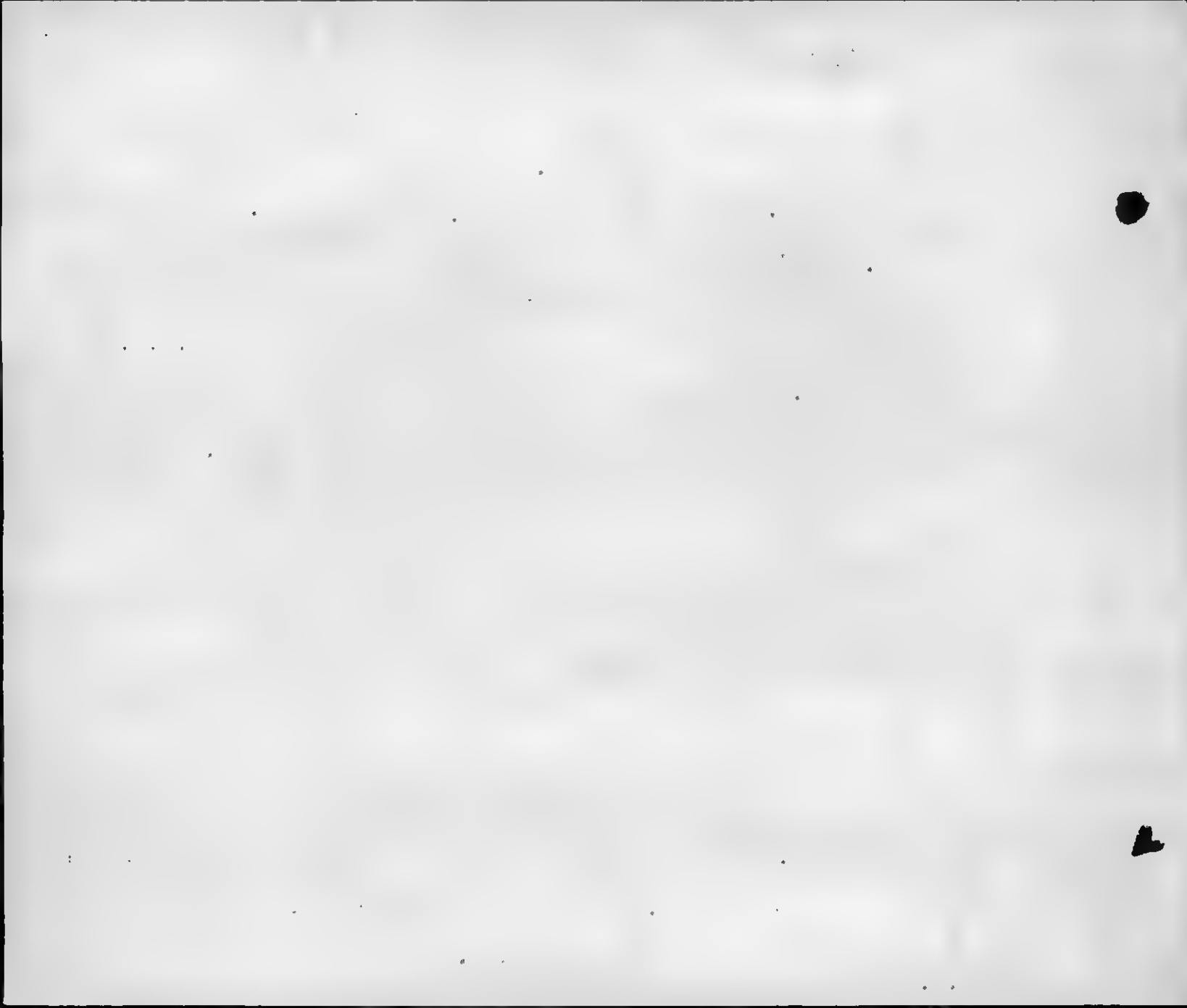
VS. A15ME  
SM 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1149 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1136

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Easton</b> c. LENGTH OF STAY IN <b>11 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington St.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Easton</b> d. STREET ADDRESS <b>113 N. Washington St.</b>			
3. NAME OF DECEASED (Type or print) <b>Wm. Paul Callahan</b>		4. DATE OF DEATH <b>1 12 1961</b>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>8-3-1917</b>		9. AGE (In years [ ] birth day [ ] yrs. <b>43</b> )		10. IF UNDER 1 YEAR Months [ ] Days [ ] IF UNDER 24 HRS. Hours [ ] Min. [ ]			
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11c. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Lawrence C. Callahan</b>					
14. MOTHER'S MAIDEN NAME <b>Geraldine Lynch</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Eugenia Callahan</b> Address <b>214 Fred Avon Easton, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>20.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Louis S. Welty</b>		M.D. <b>Louis S. Welty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Louis S. Welty</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-16-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph</b>			
22d. LOCATION (City, town, or country) (State) <b>Cordova, Maryland</b>		23. FUNERAL DIRECTOR ADDRESS <b>J.E. Boulaais Greensboro, Md.</b>					
24a. REC'D BY REGISTRAR <b>JAN 16 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Hanna</b>					

DATE SIGNED **January 12, '60**



1150

## CERTIFICATE OF DEATH

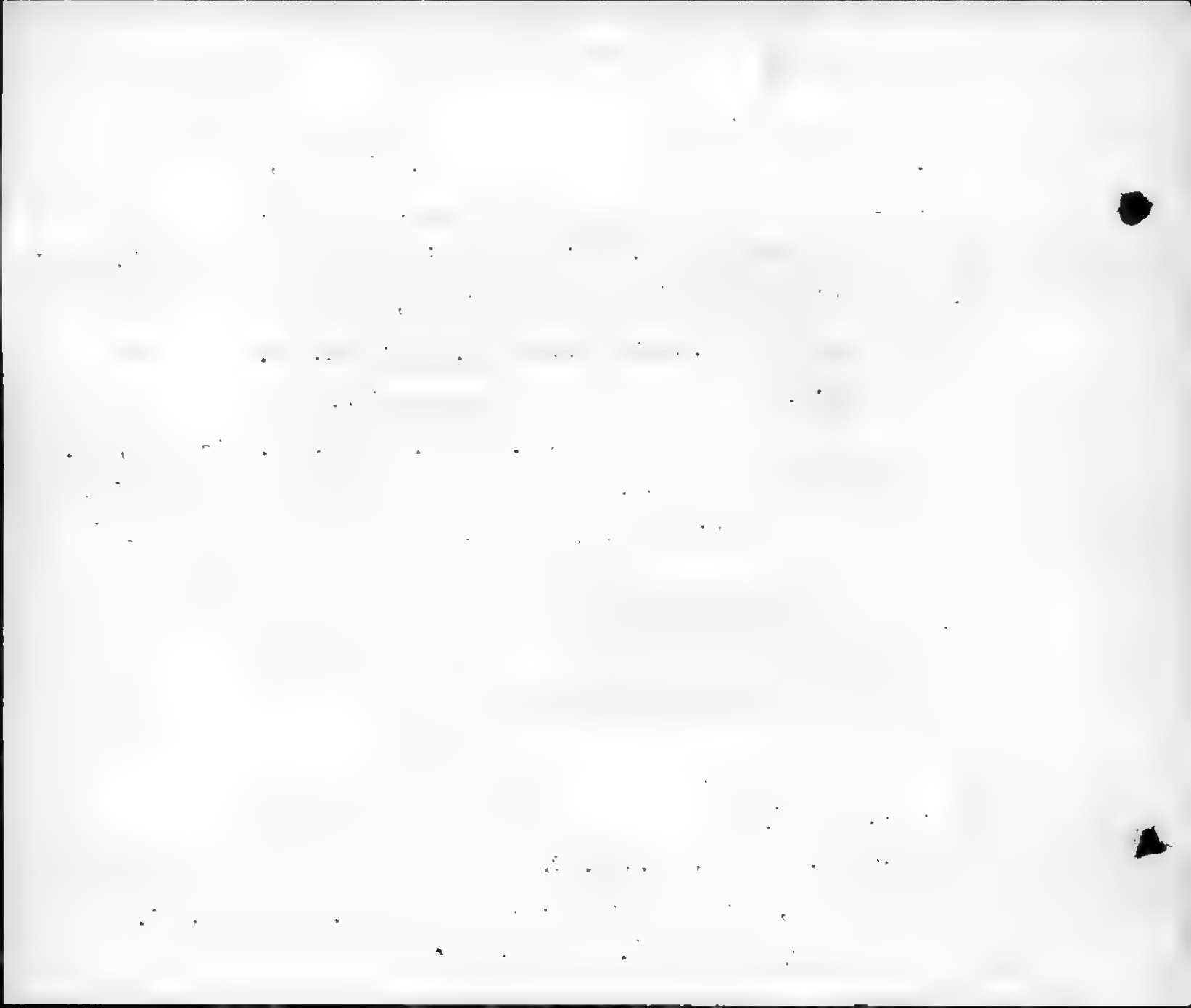
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. STREET ADDRESS <b>Seymour Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>CALVIN</b> Last <b>CAULK</b>				4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1906</b>		9. AGE (In years last birthday) <b>54</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Artesian Wells</b>		11. BIRTHPLACE (State or foreign country) <b>St. Michaels, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Caulk</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Fairbank</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>922-09-8301</b>		INFORMANT <b>Mrs. Ida S. Caulk, St. Michaels, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO (b) <b>atherosclerotic-occlusive coronary artery d.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cardiac failure - chronic</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-3</b> , 19 <b>53</b> , to <b>1-1</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1-1</b> , 19 <b>61</b> , and that death occurred at <b>12:45</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>St. Michaels Md</b> DATE SIGNED <b>1-3-60</b>							
ACTUAL SIGNATURE <b>Guy M. Reeser Jr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>GUY M. REESER, Jr., M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 3, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Christ Churchyard</b>		22d. LOCATION (City, town, or county) (State) <b>St. Michaels, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Hamilton Harrison</b> ADDRESS <b>St. Michaels Md</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thompson</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)  
TSM 9/58









may be rendered by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1152

## CERTIFICATE OF DEATH

Item 14 13186281 2-20-61 et

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alexander</b> Middle <b>Cooper</b> Last <b>Cooper</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>31</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/7/10/70</b>
9. AGE (In years last birthday) <b>30</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>20</b> Hours <b>12</b> Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Writer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>1-11-11-1111</b>	
17. INFORMANT <b>James B. Eglseder</b>		Address <b>Easton, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>32X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Generalized Arteriosclerosis</b> DUE TO <b>Diabetes</b> (c) <b>General Debility</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Debility</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month <b>1/12</b> Day <b>19</b> Year <b>1961</b> Hour <b>a. m.</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	20f. (City or town) <b>---</b> (County) <b>---</b> (State) <b>---</b>
21. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> 19 <b>61</b> , to <b>1/31</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>1/31</b> 19 <b>61</b> , and that death occurred at <b>7:00</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>L. J. Eglseder</b>		22b. DATE SIGNED <b>1/31/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. J. Eglseder M. D.</b>		22d. ADDRESS <b>Easton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	23b. DATE THEREOF <b>2/4/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Trappist</b>	23d. LOCATION (City, town, or county) <b>Md.</b> (State) <b>Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Eglseder</b>		25a. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1153

CERTIFICATE OF DEATH

(210)

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital Jack's Point</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. Howard Morris Dobson</u> First Middle Last 4. DATE OF DEATH <u>January 7, 1961</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 31, 1888</u> 9. AGE (In years last birthday) <u>72</u> yrs IF UNDER 1 YEAR: Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship Carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>William A. Dobson</u> 14. MOTHER'S MAIDEN NAME <u>Cordelia Dobbs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>216-09-4499</u> 17. INFORMANT <u>Mr. Pease Dobson</u> Address <u>Oxford, Maryland</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GLMERULONEPHRITIS</u> <u>450.</u> DUE TO (b) <u>ARTERIO SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>June 1-7, 1961</u> to <u>JAN. 7, 1961</u> that (I) (we) last saw the deceased alive on <u>1-7, 1961</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Donald F. Bartley</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY MD</u> 22b. DATE SIGNED <u>1-10-61</u> 22d. ADDRESS <u>EASTON, MD.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan. 9, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u> 23d. LOCATION (City, town, or county) (State) <u>Oxford, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam &amp; Son</u> ADDRESS <u>Easton, Md.</u> 25a. REC'D BY REGISTRAR <u>DATE JAN 12 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>							

MEDICAL CERTIFICATION



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

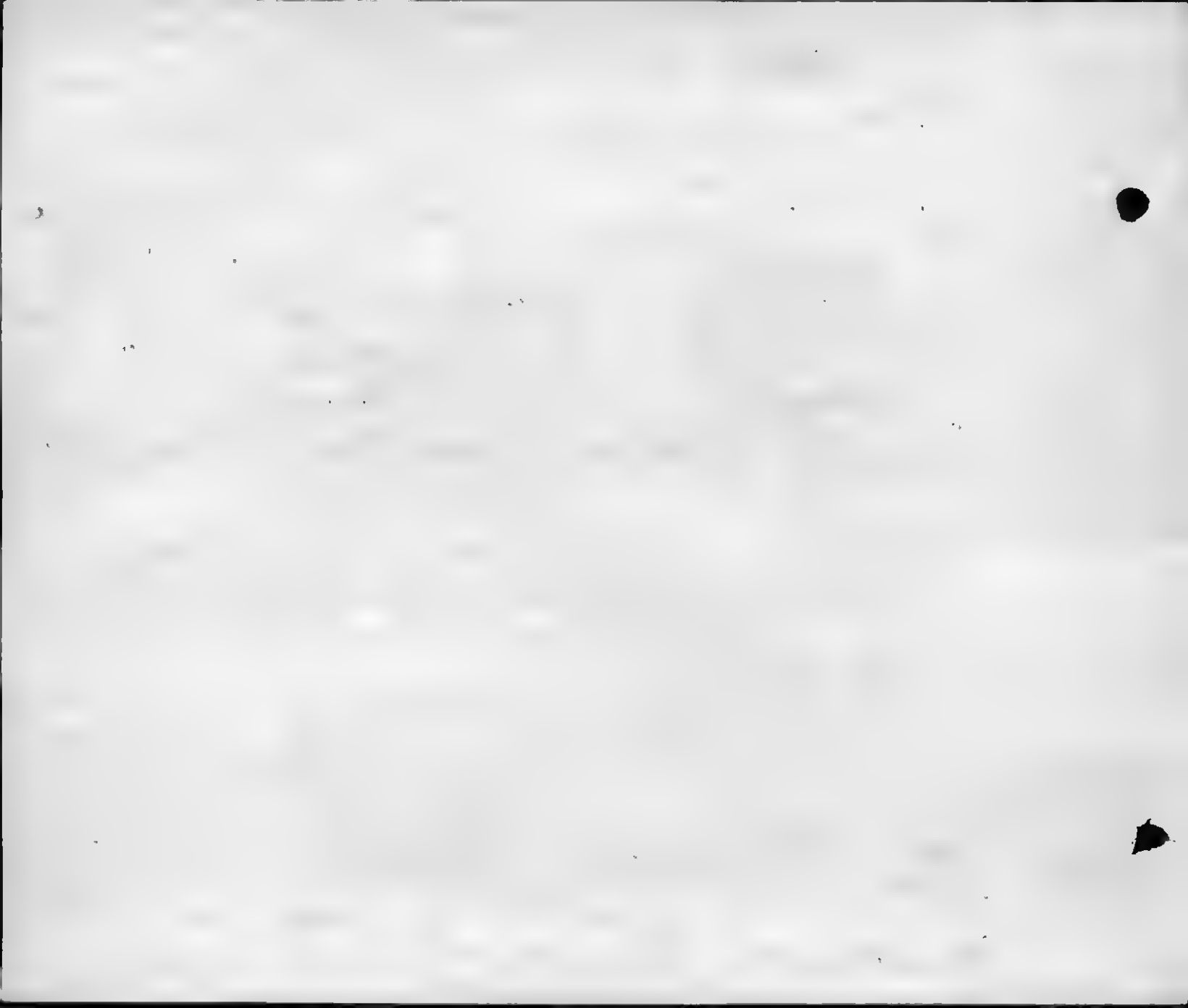
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>EASTON</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>E. DOVER ST.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TILGHMAN</b> d. STREET ADDRESS <b>CANNERY SHACKS</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First Middle Last 5. SEX <b>MALE</b> 6. COLOR OR RACE <b>COL</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4. DATE OF DEATH <b>DOZIER</b> JAN. 1 1961 8. DATE OF BIRTH <b>4-10-92</b> 68 yrs 9. AGE (In years last birthday) <b>68</b> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b> 11. BIRTHPLACE (State or foreign country) <b>Florida</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Unknown</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>?</b> 16. SOCIAL SECURITY NO. <b>218-01-6079</b> 17. INFORMANT <b>Mamie Stover</b> Address <b>Tilghman Md</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HQVD-CEREBRAL HEMORRHAGE RECURRENT</b> 443 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1-4-61</b> Address (Street, city, town, or county) _____		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-11-61</b> 22b. DATE THEREOF <b>1-11-61</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Richards Cem</b> 22d. LOCATION (City, town, or country) (State) <b>Easton Md</b>	23. FUNERAL DIRECTOR <b>James P. Shidler</b> ADDRESS <b>Easton Md</b> 24a. REC'D BY REGISTRAR <b>Chas. E. Howard</b> 24b. REGISTRAR'S SIGNATURE <b>Chas. E. Howard</b> DATE <b>JAN 16 '61</b>		

MEDICAL CERTIFICATION

2





TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND,

1155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(111)

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural-Skipton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>29 Easton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>on a Farm</b>		d. STREET ADDRESS <b>1 S. Hanson Street</b>	
3. NAME OF DECEASED (Type or print) <b>Omer Dulin</b>		4. DATE OF DEATH <b>January 29 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1897</b>
9. AGE (In years last birthday) <b>63</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming-ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Dulin</b>		14. MOTHER'S MAIDEN NAME <b>Emily Calloway</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>216-18-206</b>	
17. INFORMANT <b>Mrs. Lelia Dulin, Easton, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GSW-HEAD</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>777X</b> DUE TO cause test. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>c10A 1-29-61</b> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>FARM</b> 20f. (City or town) (County) (State) <b>SKIPTON TALBOT MD</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>January 30, 1961</b>		ACTUAL SIGNATURE <b>Louis S. Welty</b> EXAMINER'S NAME (Type) <b>Louis S. Welty, M.D.</b> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 1, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR <b>W. Frampton Carroll</b>		24a. REC'D BY REGISTRAR <b>FEB 3 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

MEDICAL CERTIFICATION



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1156

1112

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Matthew William Fisher</b>		4. DATE OF DEATH Month Day Year <b>Jan 20 1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 18, 1877</b>
9. AGE (In years last birthday) <b>83 yrs</b>		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CORR FISHER</b>		14. MOTHER'S MAIDEN NAME <b>WILSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Fannie Wilson</b>		Address <b>Chaptank Ave. Easton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema</b> DUE TO (c) <b>Diabetes mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from <b>12/23/61</b> to <b>1/20/61</b> , that (I) (we) last saw the deceased alive on <b>1/20/61</b> , and that death occurred at <b>9:05 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>E. C. H. Schmidt</b> M. D.		22b. DATE SIGNED <b>20 Jan 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>		22d. ADDRESS <b>Easton Memorial Hospital</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/23/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Easton Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Franklin Canell</b> ADDRESS <b>Easton Md.</b>		25a. REC'D BY REGISTRAR <b>Jan 23 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>James S. Evans</b>			



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

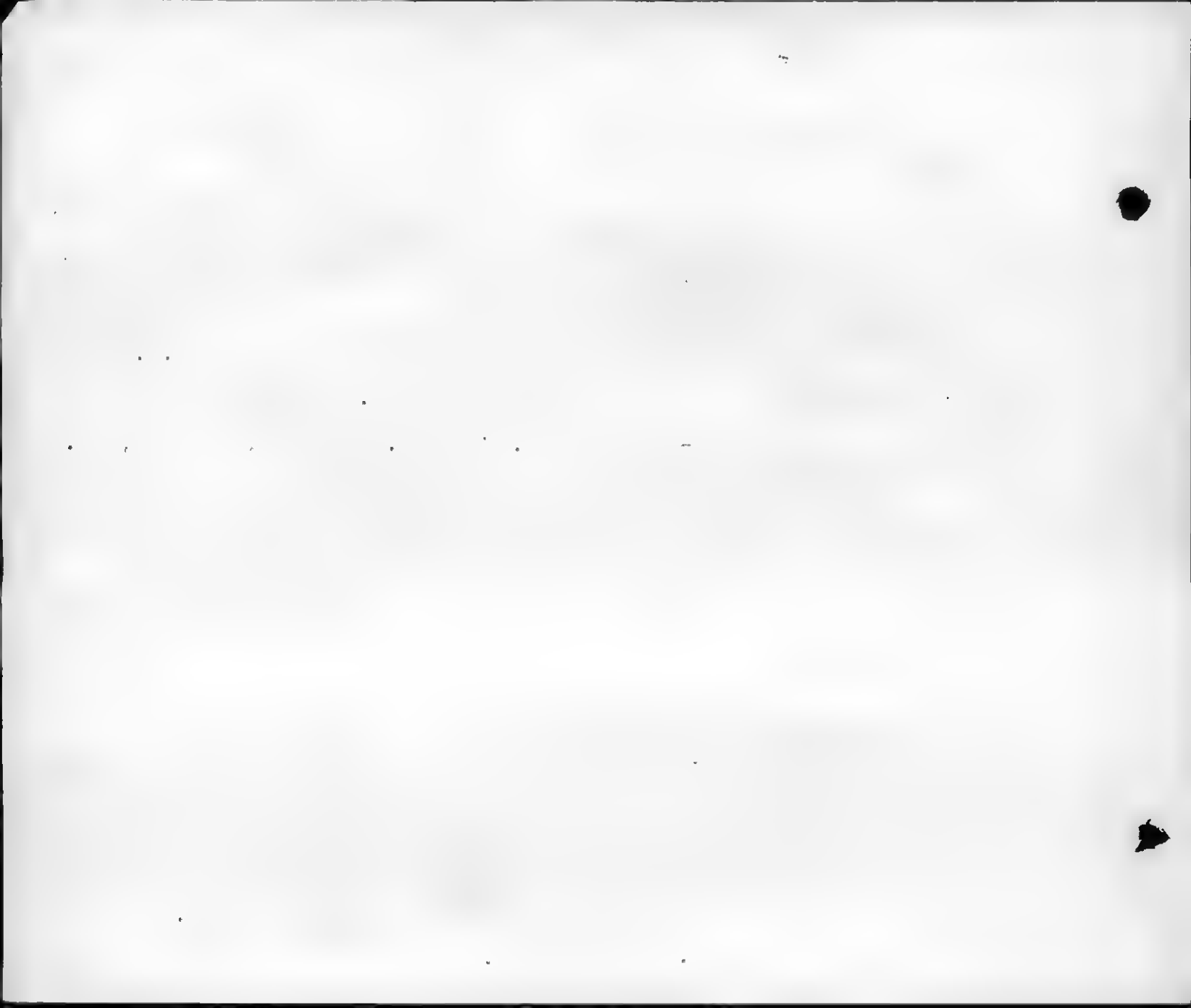
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15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1157

(1143)

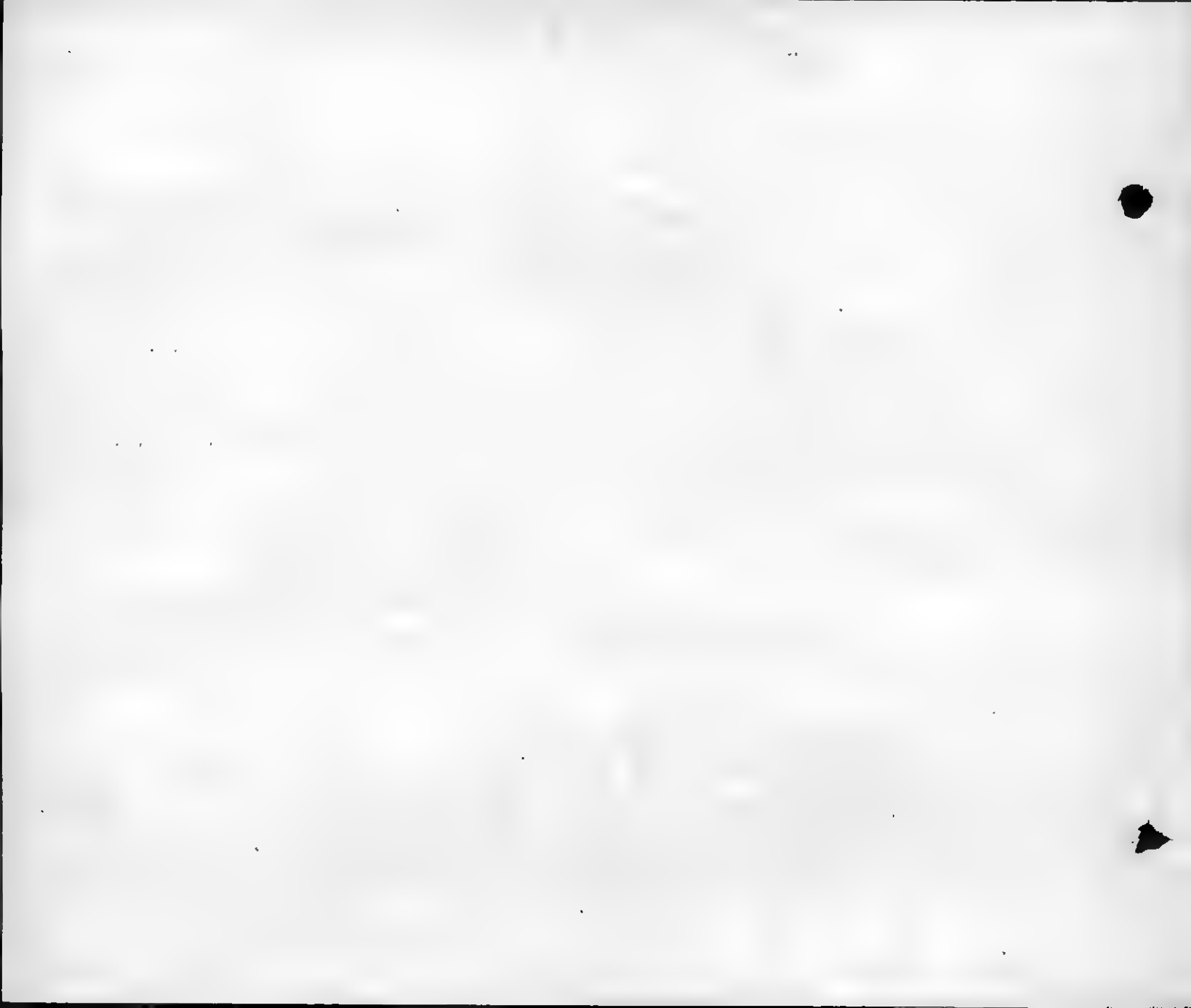
1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tilghman</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>William Howard Frampton</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/11/1886</b>	9. AGE (In years last birthday) <b>74</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Ernest Frampton</b>				14. MOTHER'S MAIDEN NAME <b>Josephine L. Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-34-6189</b>		17. INFORMANT Address <b>Mrs. Helen J. Frampton, Tilghman, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis</b> DUE TO <b>hypertension</b> (c)							INTERVAL BETWEEN ONSET AND DEATH. <b>1 month</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 29, 1961</b> to <b>Jan 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 29, 1961</b> , and that death occurred at <b>10:15</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>W. H. REISER Sr.</b>		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>W. H. REISER Sr.</b>		22d. ADDRESS <b>Tilghman, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/1/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Tilghman Methodist Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Tilghman Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Deedmore</b>		ADDRESS <b>St. Michaels, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 1 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Carlton S. Evans</b>		





1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 1158  
 CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Preston - Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>R.F.D.</i>	
3 NAME OF DECEASED (Type or print) First <i>Hannah</i> Middle <i>Clara</i> Last <i>Godow</i>		4. DATE OF DEATH Month <i>January</i> Day <i>8</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 20, 1884</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11 BIRTHPLACE (State or foreign country) <i>Abilene, Kansas</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Gottlieb Nagel</i>	
14. MOTHER'S MAIDEN NAME <i>Rosina Oetliker</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>William F. Godow, Preston, Md., R.F.D.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac failure -</i> DUE TO <i>Pulmonary embolism -</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>24 hrs.</i> DUE TO (c) <i>24 hrs.</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral artery aneurysm</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21 I certify that (I) (this hospital) attended the deceased from <i>29 Dec 1960</i> to <i>8 Jan 1961</i> , that (I) (we) last saw the deceased alive on <i>8 Jan 1961</i> , and that death occurred at <i>8:00 A.M.</i> from the causes and on the date stated above	
22a. SIGNATURE <i>Thurston Harrison</i> M.D.		22b. DATE SIGNED <i>8 Jan 61</i>	
22c. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>		22d. ADDRESS <i>Carlton Wayland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Jan. 11, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Hill Crest Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Federalburg, Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Frampton</i>		25a. REC'D BY REGISTRAR <i>JAN 12 61</i>	
ADDRESS <i>Easton, Federalburg, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. By the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1159  
CERTIFICATE OF DEATH

(1145)

1 PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Doston</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		d. STREET ADDRESS <b>213 Vesper Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Magdalena Henrietta Gibson</b>		4. DATE OF DEATH Month Day Year <b>January 24 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Weber</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Schmidt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. J. Stanley Long, Federalsburg, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>350X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <b>Cerebral Vascular Accident</b>	
(c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs?</b>	
(c) <b>Parkinson's disease -</b>		<b>3 yrs -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1960</b> to <b>Jan. 1961</b> that (I) (we) last saw the deceased alive on <b>Jan. 24, 1961</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>H. R. Trapnell</b>		22b. DATE SIGNED <b>January 25, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. R. Trapnell, M.D.</b>		22d. ADDRESS <b>Federalsburg, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 28, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Airy Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Netrona Heights, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frantom and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 27 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Orlino S. House</b>	

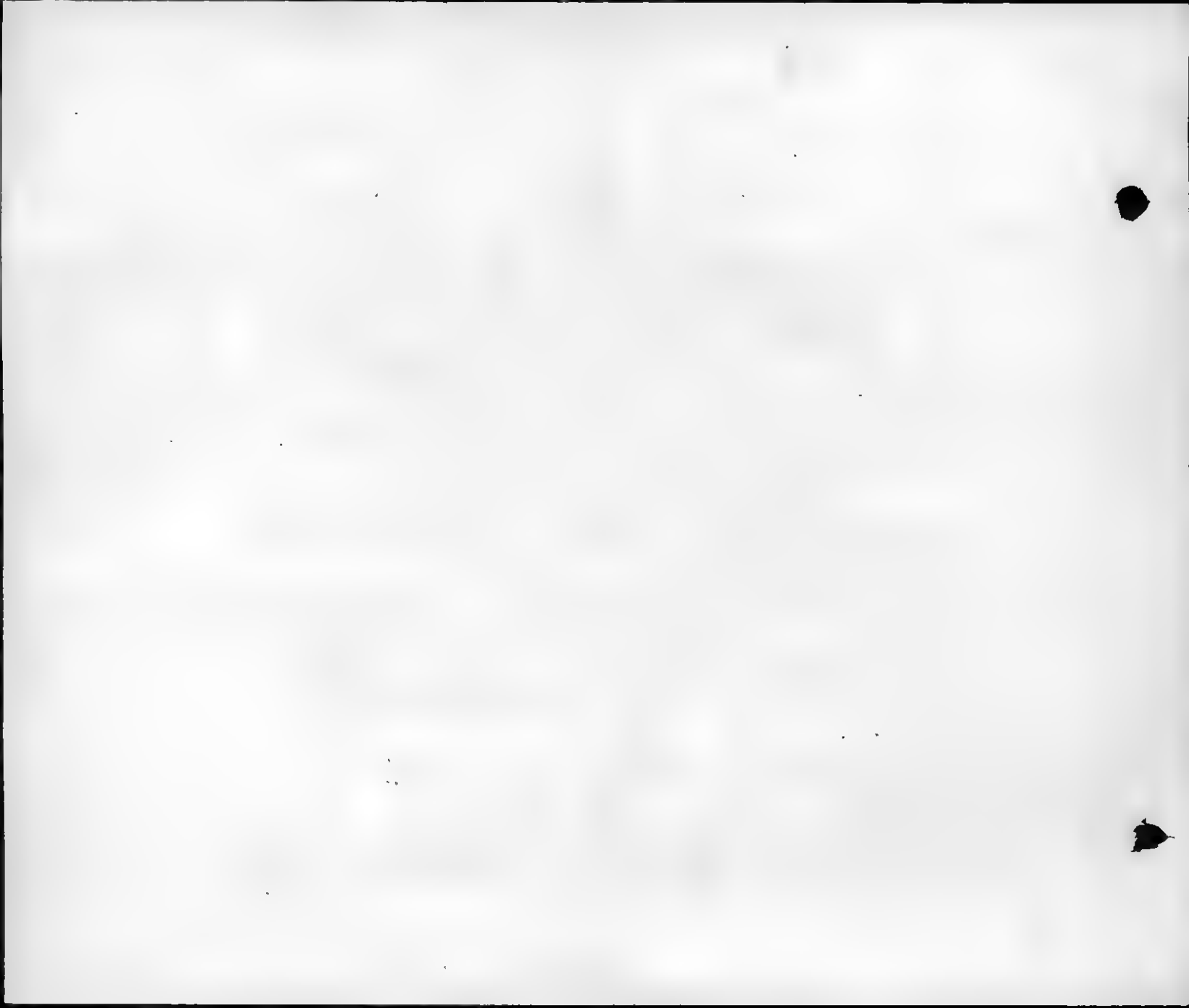


1160  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

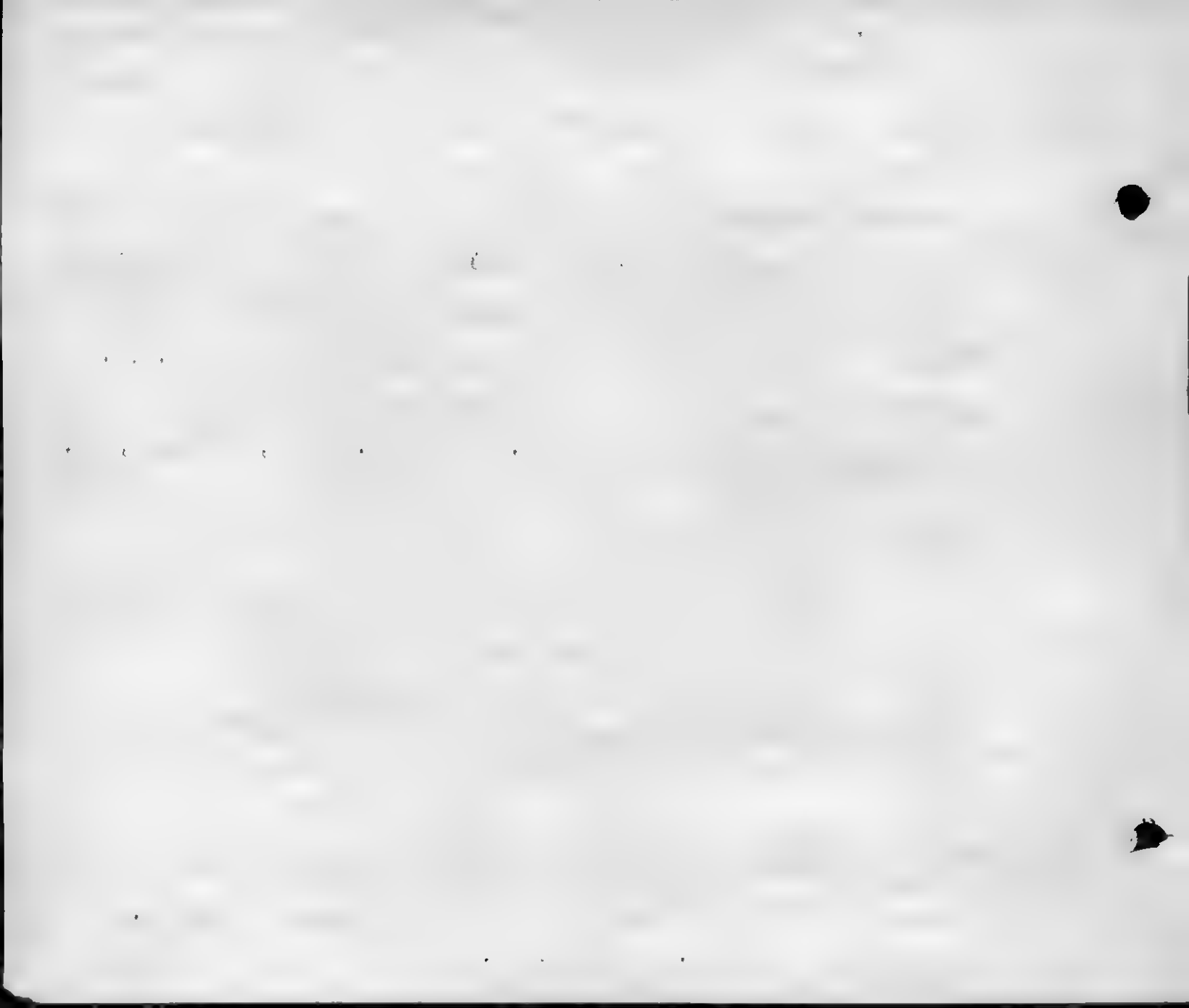
61146

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON 9 mi. 40 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hosp.</b>		d. STREET ADDRESS <b>GAY ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Gleaton</b> Last <b>Gleaton</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 24, 1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>1</b> yrs	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES GLEATON</b>		14. MOTHER'S MAIDEN NAME <b>ERGENIA ROBINSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles Gleaton, Denton, Ind.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 493x <b>DOE TO</b> <b>Pulmonary embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DOE TO</b> <b>Heart failure</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1940</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>19</b> and that death occurred at <b>12 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. C. H. Schmidt</b> M. D.		22b. DATE SIGNED <b>25 JAN 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>		22d. ADDRESS <b>Denton, Ind.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>Jan 26, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>		23d. LOCATION (City, town, or county) (State) <b>Denton, Ind.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b> ADDRESS <b>Denton</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 30 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION









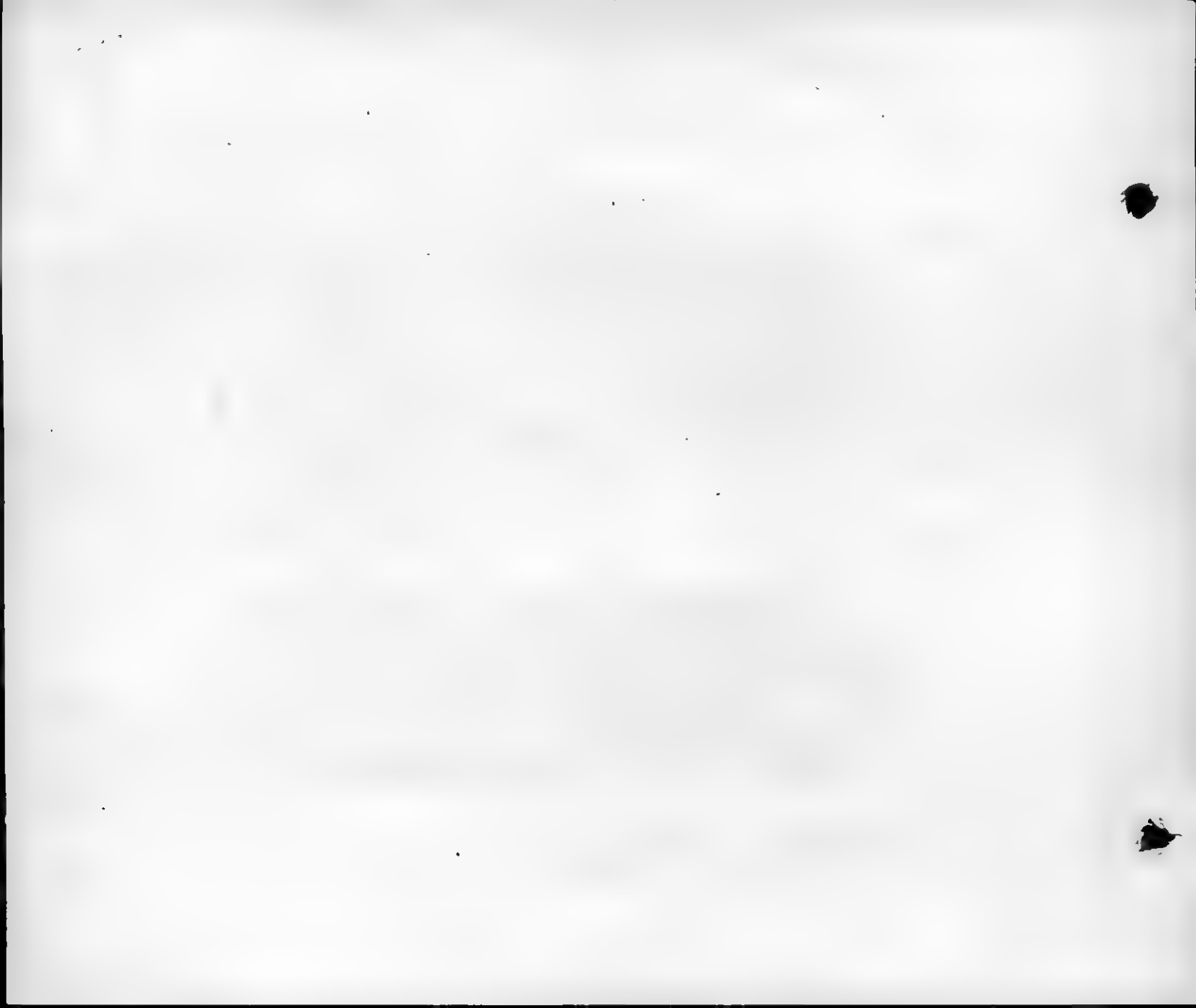
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1162

1143

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTER</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hosp.</b>				d. STREET ADDRESS <b>17X-2</b>			
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>Raymond</b> Last <b>Langley</b>				4. DATE OF DEATH Month <b>1</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 9 - 1896</b>	
9. AGE (In years last birthday) <b>64</b> yrs		IF UNDER 1 YEAR Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min <b>64</b>		IF UNDER 24 HRS. Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min <b>64</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>LANGLEY</b>				14. MOTHER'S MAIDEN NAME <b>MARY MORGAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>218-03-4273</b>			
17. INFORMANT <b>MRS. LANGLEY</b>				Address <b>CHESTER MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage, left</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>331X</b> DUE TO							
(c) <b>331X</b> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331X</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) this hospital attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased on <b>19</b> , and that death occurred at <b>9:20</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>E. C. H. Schmidt</b>				22b. DATE <b>16/25/1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>				22d. ADDRESS <b>Easton, Maryland</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stevensville</b>		23d. LOCATION (City, town, or county) (State) <b>Stevensville MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>				25a. REC'D BY REGISTRAR <b>17 '61</b>			
ADDRESS <b>Church Hill Md.</b>				25b. REGISTRAR'S SIGNATURE <b>William S. Hume</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1163

CERTIFICATE OF DEATH

05149

1. PLACE OF DEATH a. COUNTY <u>Trialbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>9 days.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>R. F. K.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha E. Lockwood</u>		4. DATE OF DEATH Month Day Year <u>January 20 1961</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/1893</u>
9. AGE (in years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Easton Md.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Conway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Francis Stanford</u>		Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastasized lymphosarcoma</u> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>12/14/60</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmidt</u> M.D.		22b. DATE SIGNED <u>22 Jan 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		22d. ADDRESS <u>Baltimore, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/27/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>M. I. C.</u>	23d. LOCATION (City, town, or county) (State) <u>Lincoln Park</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Ashwell</u> ADDRESS <u>Easton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 25 61</u>	25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1164

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15156

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>None</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Matthews</u>				4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1879</u>		9. AGE (In years last birthday) <u>81</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anderson Matthews</u>				14. MOTHER'S MAIDEN NAME <u>Heneritta Sudler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-14-3211</u>		17. INFORMANT Address <u>Elbert Matthews Goldsboro, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>334X</u> IMMEDIATE CAUSE (a) <u>apoplexy</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis, generalized</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-2-1961</u> to <u>1-2-1961</u> , that (I) (we) last saw the deceased alive on <u>1-2-1961</u> , and that death occurred at <u>9:50</u> A.M. from the causes and on the date stated above							
22a. SIGNATURE <u>P. E. Cox</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/6/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>P. E. Cox M.D.</u>		22d. ADDRESS <u>Easton, Maryland</u>		1/6/61			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-7-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		23d. LOCATION (City, town, or county) (State) <u>Goldsboro, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Bouclair Greensboro, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE JAN 9 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. S. Thomas</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1165

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1151

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Har</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>2 4 hrs 20 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>Nichols</u>				4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1961</u>			
5 SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>July 14, 1873</u>	
9 AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u>		IF UNDER 24 HRS			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>La orer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11 BIRTHPLACE (State or foreign country) <u>Dorchester Co., Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Nichols</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17 INFORMANT Address <u>Mrs. Martle Pinder, Hurlock, Md., R.T.D.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction due to gall</u> 575-1 DUE TO <u>stone ileus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>stone ileus</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>9 pm</u> , 19 <u>61</u> , to <u>10 pm</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10 pm</u> , 19 <u>61</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.							
22a SIGNATURE <u>Thurston Harrison</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>10 pm 6/1</u>	
22c PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>				22d ADDRESS <u>Carlton Maryland</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b DATE THEREOF <u>Jan. 15, 1961</u>		23c NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		23d LOCATION (City, town, or county) (State) <u>Near Harl ck, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton &amp; Son</u>				ADDRESS <u>FEDERALSBURG, MD.</u>		25a REC'D BY REGISTRAR DATE <u>JAN 12 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Carlton Maryland</u>			

1

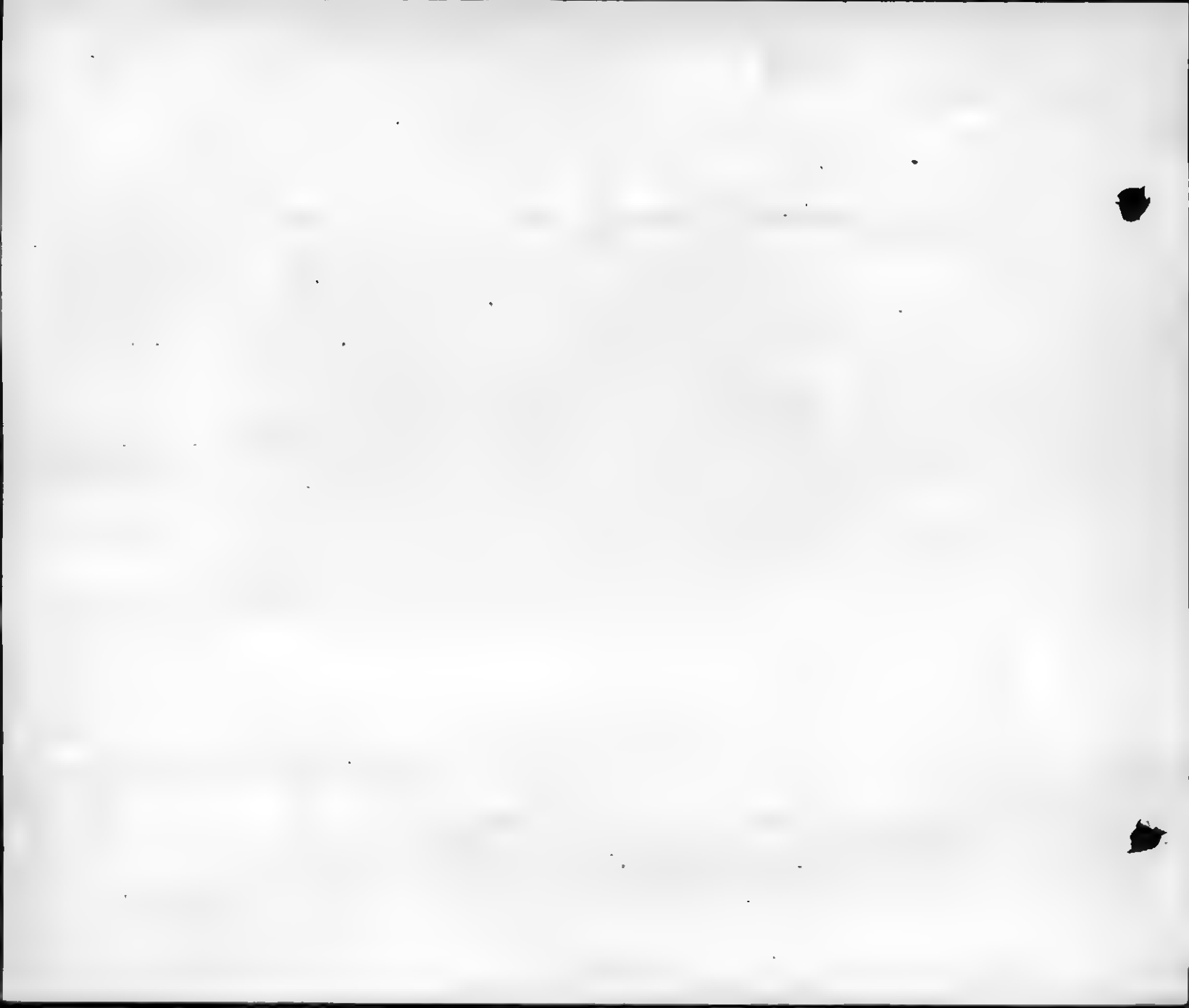
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1166

## CERTIFICATE OF DEATH

Reg. Dist. No. 1152

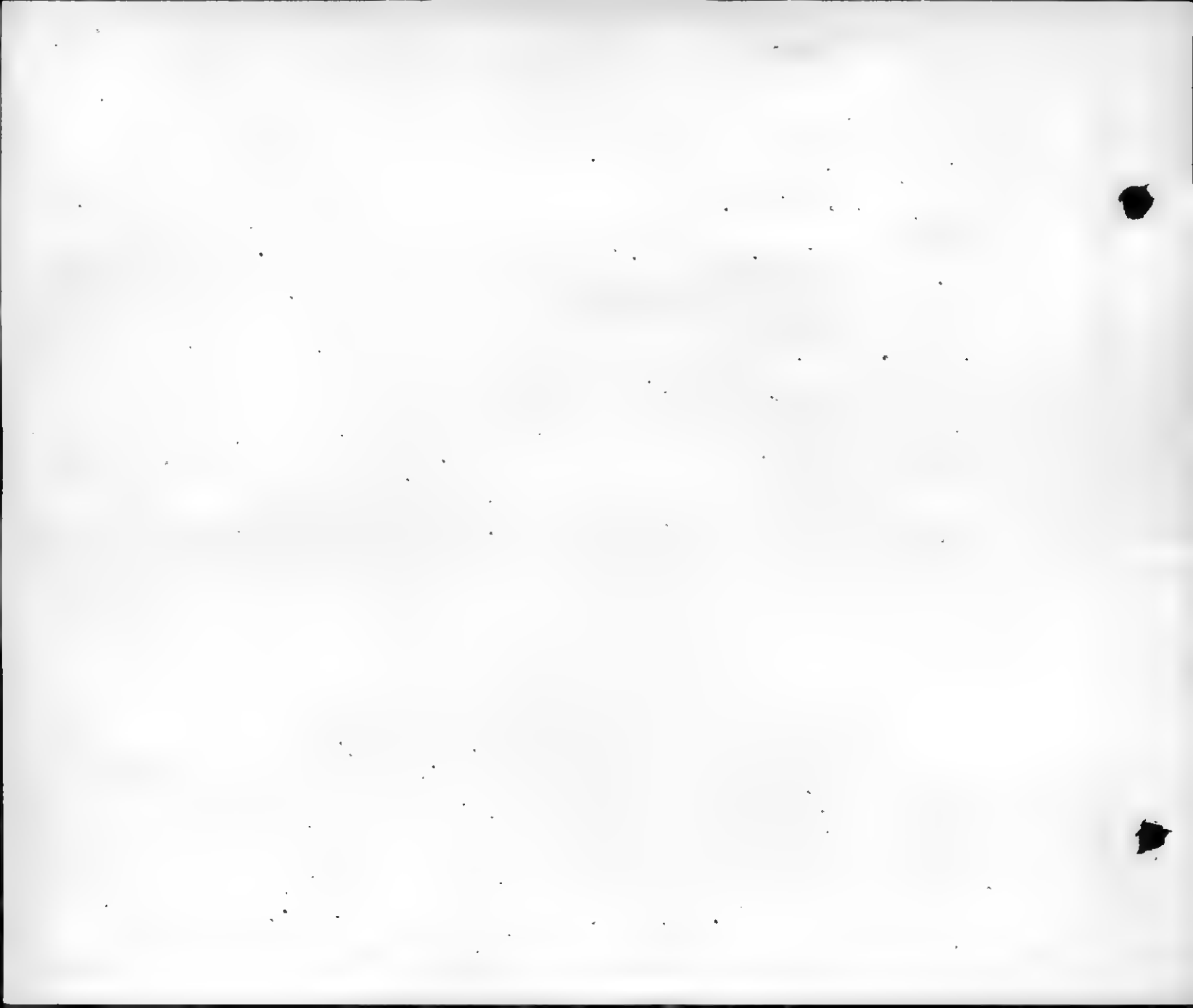
1 PLACE OF DEATH a. COUNTY <u>Tackett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Tackett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural St. Michaels</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oxford</u>	
NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>His Sister's Nursing Home</u>		d. STREET ADDRESS <u>1</u>	
3 NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>M.</u> Last <u>Plummer</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1866</u> 9. AGE (In years last birthday) <u>94</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cum Reme</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W. Farland</u>		14. MOTHER'S MAIDEN NAME <u>Martha Plummer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Bronchopneumonia</u> <u>422.1</u> DUE TO (b) <u>Chronic Cardiac Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-22</u> 19 <u>61</u> , to <u>1-24</u> 19 <u>61</u> , that I last saw the deceased alive on <u>1-24</u> 19 <u>61</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Kane Wrath</u> M.D.		DATE SIGNED <u>Jan 27, 1961</u>	
PHYSICIAN'S NAME (Type) <u>R. Kane Wrath</u>		ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 27, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Chesapeake</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Kane</u>		24a. REC'D BY REGISTRAR <u>Jan 30 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



1167

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

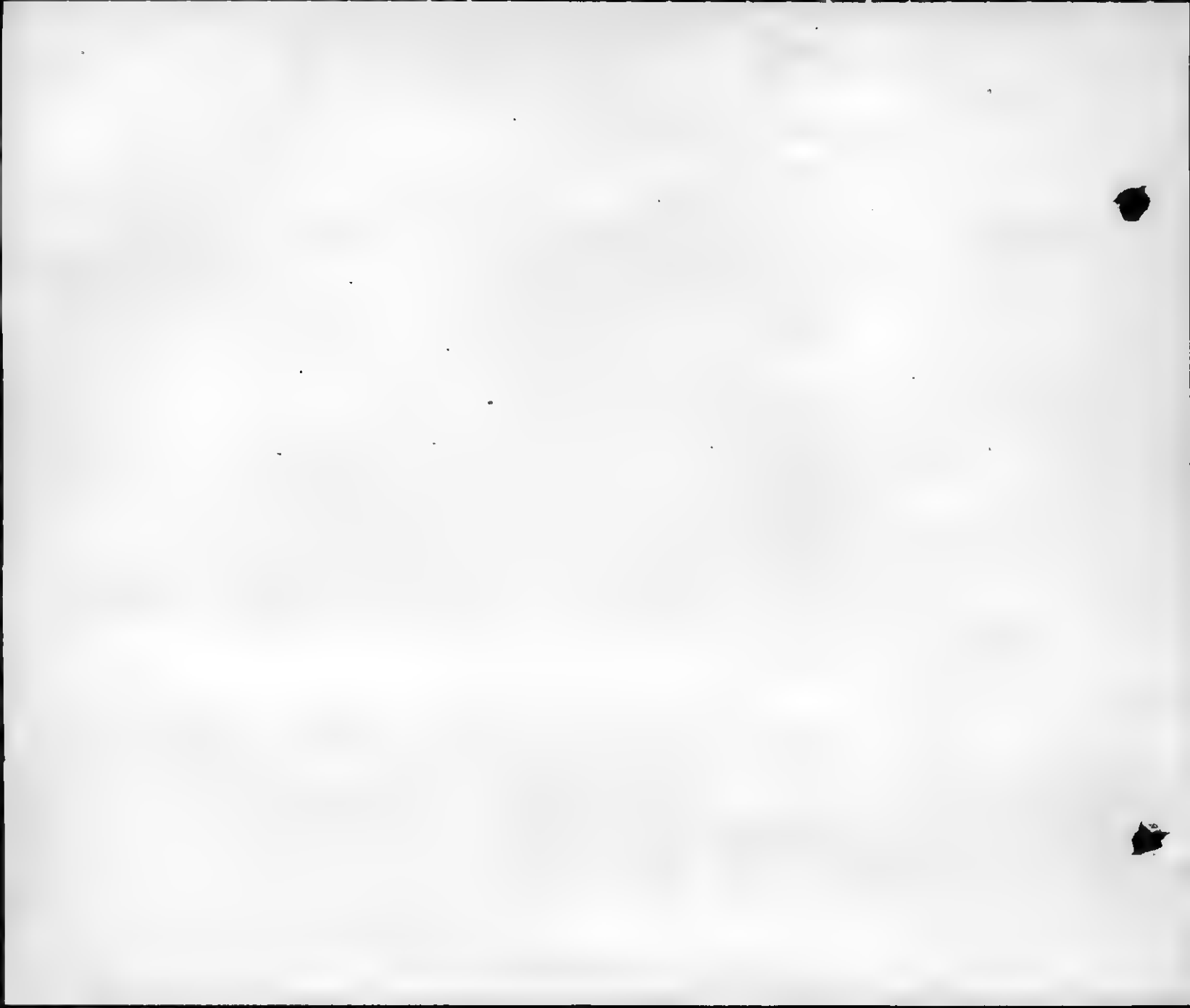
### CERTIFICATE OF DEATH

(1153)

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>3 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>Lee</u> Last <u>Roe</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 22, 1895</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School bus driver</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William Andrew Roe</u>		14. MOTHER'S MAIDEN NAME <u>Emma Stubbs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W. I 220-32-0443</u>		17. INFORMANT <u>Mrs. Frank Roe</u> Address <u>Easton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Cancer</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma sigmoid</u> DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>18 59</u> a. _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>5</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 25, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Junior Under Cemetery</u>		23d. LOCATION (City, town, or county) <u>Preston</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice F. Newman &amp; Son</u> ADDRESS <u>Easton, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AYS (4)  
15M 9/59

1168

STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

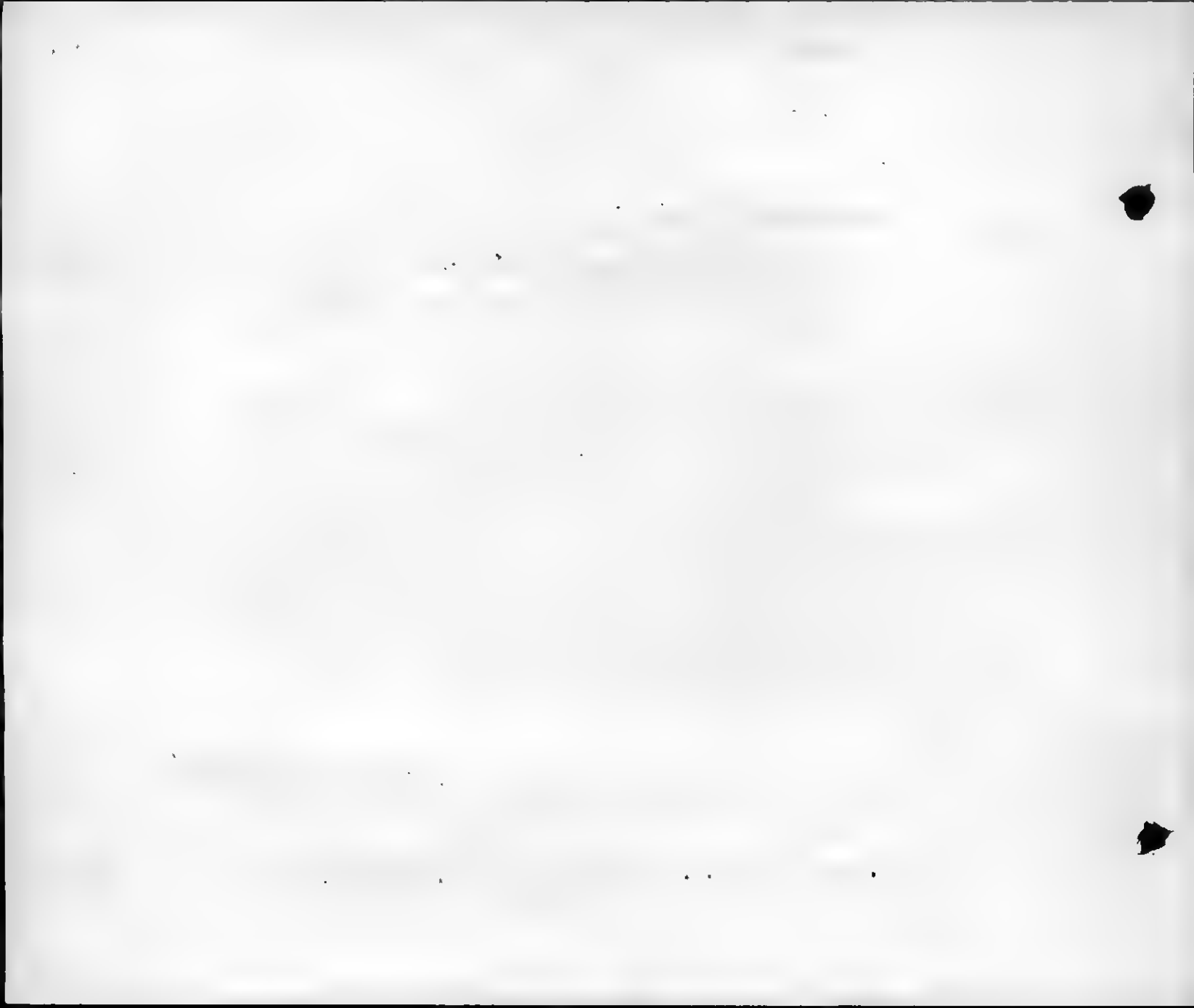
CERTIFICATE OF DEATH

See: Birth Cert. et

1154

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>	
c. LENGTH OF STAY IN 1b <u>25 hours</u>		d. STREET ADDRESS <u>---</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Stanford</u>		4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 25, 1961</u>
9. AGE (In years last birthday) <u>1</u> yrs <u>1</u> mo <u>1</u> day <u>25</u> hrs <u>1</u> min		10. BIRTHPLACE (State or foreign country) <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Jackson Deshields</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Mary Stanford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mother</u>		Address <u>St. Michaels, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> 762.5 DUE TO (b) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>---</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-25</u> 19 <u>61</u> , to <u>1-26</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-25</u> 19 <u>61</u> , and that death occurred <u>3:45</u> AM, from the causes and on the date stated above			
22a. SIGNATURE <u>R. Lane Wroth</u>		22b. DATE SIGNED <u>1/31/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth M.D.</u>		22d. ADDRESS <u>St. Michaels, Maryland</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Incineration</u>		23b. DATE THEREOF <u>1/30/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u>		23d. LOCATION (City, town, or county) <u>Easton, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>INCINERATION (MEMORIAL HOSPITAL)</u>		25a. REC'D BY REGISTRAR <u>FEB 1 1961</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Christ S. Brown</u>	

8XV1



1169

CERTIFICATE OF DEATH

Reg. Dist. No.

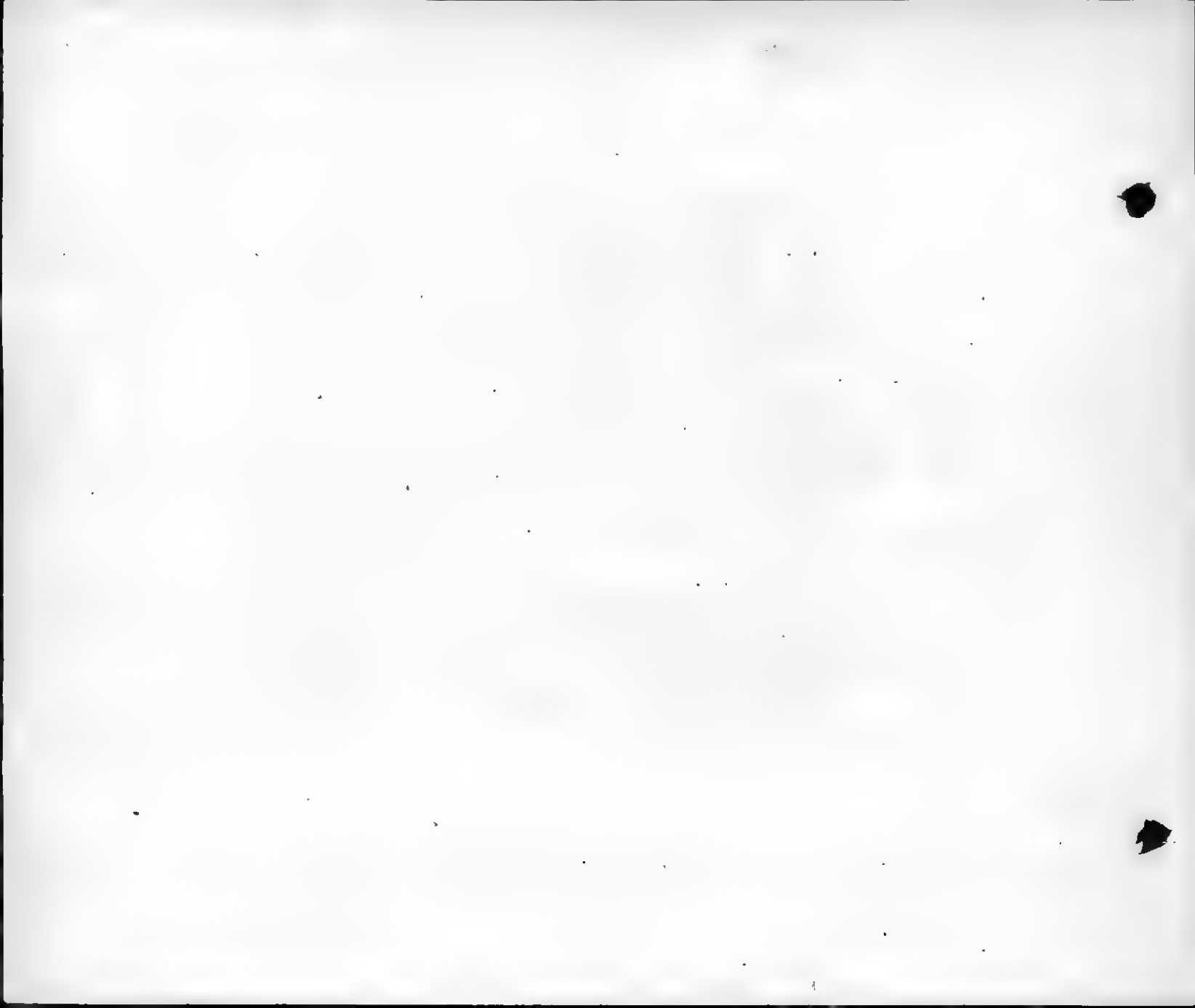
1155

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. MICHAELS</b> c. LENGTH OF STAY IN 1b <b>18 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private home</b>		2. USUAL RESIDENCE (Where deceased lived If institut on. Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>TALBOT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. MICHAELS RURAL</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GLADYS</b> First <b>I. STEEVER</b> Middle <b>STEEVER</b> Last 5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>JAN 9 1888</b> 9. AGE (In years lost birthday) <b>72</b> yrs. 10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS		4. DATE OF DEATH <b>JAN 21 1961</b> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <b>WATERTOWN, N.Y.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>H.F. INGHART</b> 14. MOTHER'S MAIDEN NAME <b>A.D. BLODGETT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>-</b> 16. SOCIAL SECURITY NO. <b>197-26-6761</b> 17. INFORMANT <b>M.D. Steever, St. Michaels, Md</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial failure</b> 199.2 DUE TO <b>cachexia - severe generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last <b>carcinomatous - generalized</b> (b) <b>carcinomatous - generalized</b> (c) <b>carcinomatous - generalized</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>3 mo 1</b> <b>-</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>carcinomatous - metastatic</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-10</b> , 19 <b>53</b> , to <b>1-21</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1-21</b> , 19 <b>61</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>St. Michaels, Md</b> DATE SIGNED <b>1-23-61</b> ACTUAL SIGNATURE <b>Guy M. Reese, Jr.</b> M.D. <b>St. Michaels, Md</b> PHYSICIAN'S NAME (Type) <b>St. Michaels, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>1-25-61</b> 22c. NAME OF CEMETERY OR PREMATORY <b>Oak Hill Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>St. Michaels, Md</b> ADDRESS <b>St. Michaels, Md</b> 24a. REC'D BY REGISTRAR <b>JAN 30 '61</b> 24b. REGISTRAR'S SIGNATURE <b>William S. Kane</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58





TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1170

61156

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Weston</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Weston</u>	
3. NAME OF DECEASED (Type or print) First <u>Levin</u> Middle <u>Byrd</u> Last <u>Swartz</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 4 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Comm. Comm.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Swartz</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Zink</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-70-5575</u>	
17. INFORMANT <u>McDonald Society</u>		Address <u>P.O. Box 797</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH MINUTES <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>53</u> to <u>JAN. 23</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>JAN. 23</u> , 19 <u>61</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Donald F. Bartley</u> M.D.		22b. DATE SIGNED <u>1-23-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY, M.D.</u>		22d. ADDRESS <u>9 N. HANSON ST. EASTON, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 24 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Easton Talbot Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McDonald</u> ADDRESS <u>Easton Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 25 61</u>	
		25b. REGISTRAR'S SIGNATURE <u>McDonald</u>	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
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the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

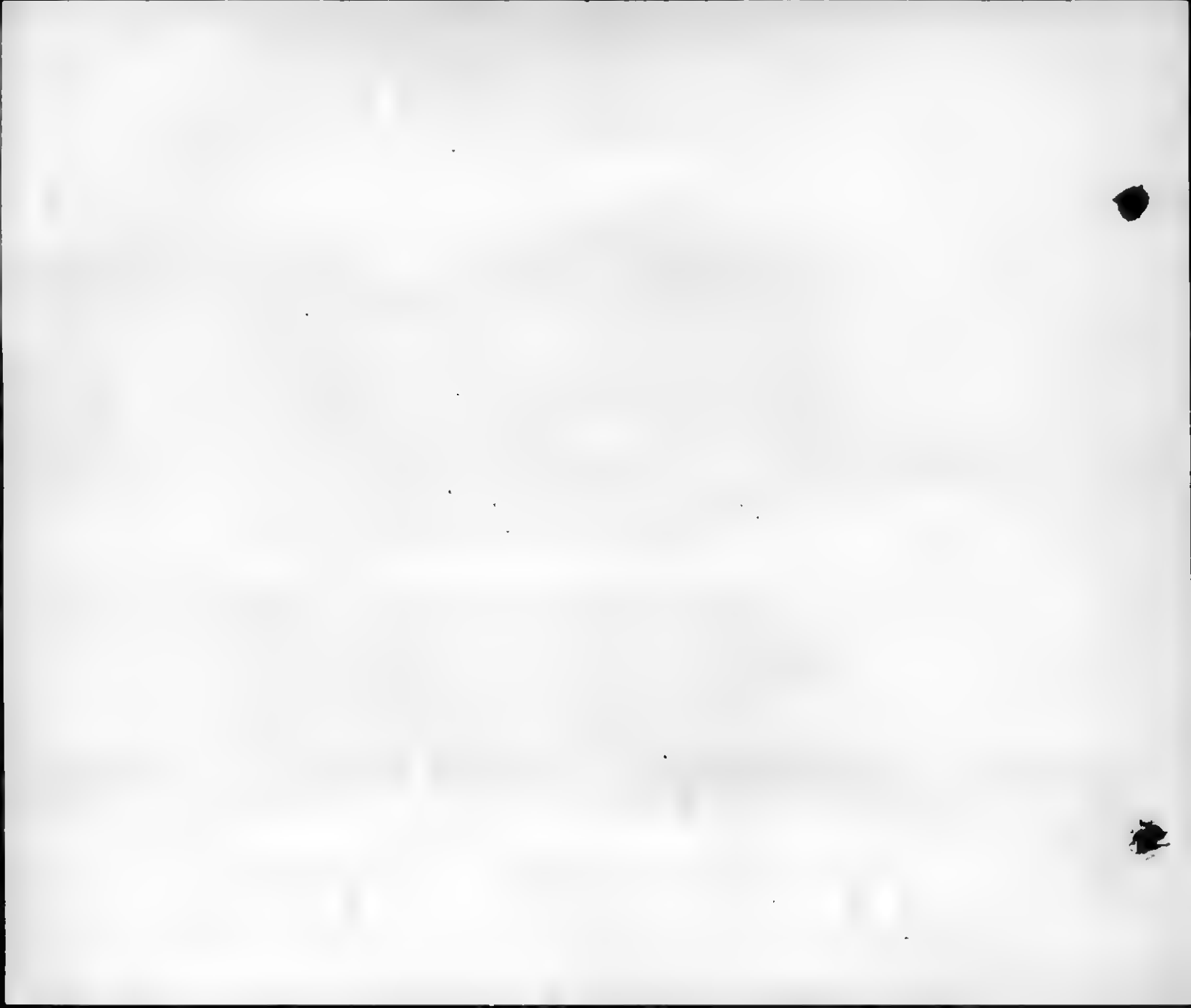
VR AIS (4)  
ISM 9/59

1171  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

61157

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>C. E. ...</u>	
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>E</u> Last <u>Thawley</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1891 JAN 3, 1941</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months <u>...</u> Days <u>...</u> Hours <u>...</u> Min <u>...</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>house</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willard J. Thawley</u>		14. MOTHER'S MAIDEN NAME <u>Harriett E. Jewell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>...</u>	
17. INFORMANT <u>Mrs. Charles Wells, Denton, Md.</u>		Address <u>...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Emphysema</u> (c) <u>...</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>...</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>...</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>...</u> 19 <u>...</u> , to <u>...</u> 19 <u>...</u> , that (I) (we) last saw the deceased alive on <u>...</u> and that death occurred <u>...</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmitt</u>		22b. DATE <u>3 Jan 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmitt</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 6, 1961</u>		23b. DATE THEREOF <u>Jan 6, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		23d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Monahan</u>		25a. REC'D BY REGISTRAR <u>...</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M-9739

1172

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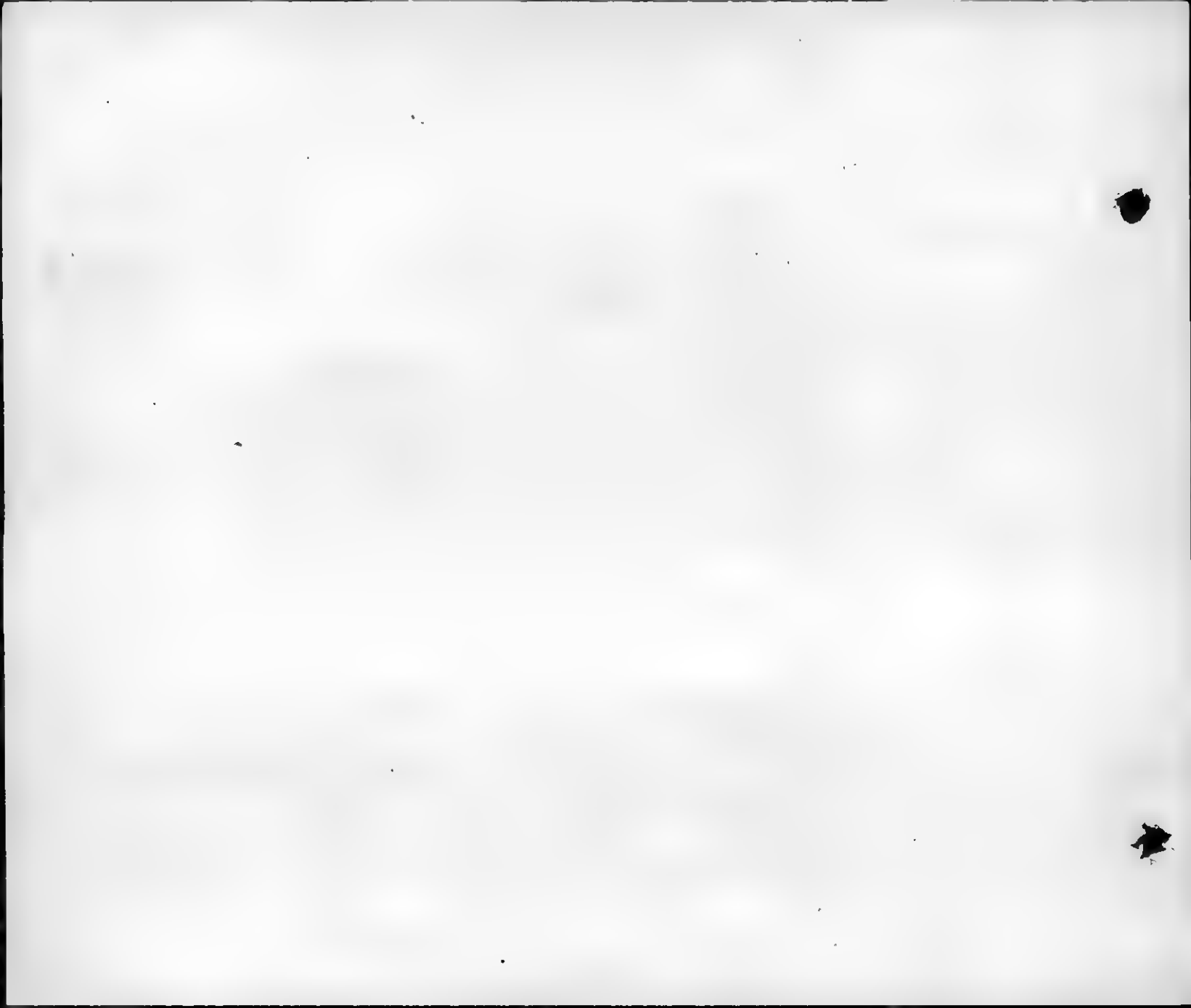
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1158

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. STREET ADDRESS <u>Queen Anne</u>	
3. NAME OF DECEASED (Type or print) First <u>Shelia</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 21 1960</u>
9. AGE (In years last birthday) yrs. <u>13</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Little Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mary Ann Thomas - mother</u>		Address <u>none</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure due To</u> DUE TO <u>7cc.o</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diarrhea, Dehydration</u> DUE TO <u>Cerebral hemorrhage</u> (c) <u>Cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 31 1960</u> to <u>Jan 2 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 2 1961</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John E Baybutt</u>		22b. DATE SIGNED <u>1-4-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John E. Baybutt</u>		22d. ADDRESS <u>205 Earle Ave Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Newtown Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Talbot County, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Thompson Carroll</u>		25a. REC'D BY REGISTRAR <u>Easton, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>C. S. S. Kline</u>		DATE <u>JAN 11 '61</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 9/59

11774

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1160

Item 2 Film 0280 2-2-61 et

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home-- 122 West Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>A.</u> Last <u>Townsend</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 21, 1893</u> AGE (In years last birthday) <u>67</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Supplies</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Townsend</u>				14. MOTHER'S MAIDEN NAME <u>Ida M. Starkey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 09-9139</u>		17. INFORMANT <u>Wm. H. Townsend</u>		Address <u>122 West St. Easton Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <u>152.9</u> DUE TO <u>Metastatic Carcinoma of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Carcinoma of colon</u> (b) <u>4 yrs.</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>50</u> to <u>25 Feb</u> , 19 <u>61</u> . that (I) (we) last saw the deceased alive on <u>22 Jan</u> , 19 <u>61</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. H. Harrison</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>27 Jan 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILKINSON HARRISON</u>				22d. ADDRESS <u>Easton Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 28, 1961</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		23d. LOCATION (City, town, or county) <u>Easton Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Harrison</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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1175

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

(1161

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN 1b <b>5 Minutes</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>				d. STREET ADDRESS <b>None</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Frederick Walls</b>				4. DATE OF DEATH Month Day Year <b>January 5 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-7-1879</b>	
9. AGE (in years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Tennant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Walls</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta Phillips</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>William Walls Ridgely, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Hypertension</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>October 5, 1961</b> to <b>Jan 5, 1961</b> that (I) (we) last saw the deceased alive on <b>Jan 5, 1961</b> , and that death occurred at <b>5</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles H. Winnacott</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>CHARLES H. WINNACOTT</b>				22d. ADDRESS <b>Ridgely, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-8-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ridgely</b>		23d. LOCATION (City, town, or county) (State) <b>Ridgely, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. E. Boulares Greensboro, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. G. House</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1176

## CERTIFICATE OF DEATH

Reg. Dist. No.

16

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Tilghman</b>				c. LENGTH OF STAY IN 1b <b>4 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Tilghman</b>			
f. STREET ADDRESS				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>Hoffman</b> Last <b>Watkins</b>				4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 26, 1891</b>	
9. AGE (In years last birthday) yrs. <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer-Ret.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Marion Watkins</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Strong</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO <b>12 03 1882</b>		17. INFORMANT <b>Mrs. Eleanor K. Watkins, North Tilghman, /</b>		Address <b>Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Over exertion after fighting</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart. Died suddenly</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10, 1961</b> to <b>Jan 10, 1961</b> , that I last saw the deceased alive on <b>Jan 10, 1961</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Talghman Md Jan 10 1961</b> DATE SIGNED							
ACTUAL SIGNATURE <b>GUY M REESER Sr</b>				PHYSICIAN'S NAME (Type) <b>GUY M REESER Sr</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/13/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>N. Frampton Carroll</b> ADDRESS <b>St. Michaels, Md</b>				24a. REC'D BY REGISTRAR <b>JAN 12 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**1177**

**1163**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>TALBOT</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>10 hrs 10 min</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>Martinswood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>St. Clair</u> Middle <u>WATTS</u> Last <u>WATTS</u> <b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>11</u> Year <u>1961</u>				<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1-1-37</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>24</u> <b>10. UNDER 1 YEAR</b> Months <u>11</u> Days <u>11</u> <b>11. UNDER 24 HRS</b> Hours <u>10</u> Minutes <u>10</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>				<b>13. FATHER'S NAME</b> <u>St. Clair</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Watts</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>216-38-0914</u> <b>17. INFORMANT</b> <u>Watts</u> Address <u>11617 11th St, Easton, Md</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cell carcinoma of face</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>face</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> (b) <u>None</u> (c) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>11/1/61</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> <b>20c. TIME OF INJURY</b> Month <u>11</u> Day <u>13</u> Year <u>1961</u> Hour <u>11</u> a.m. <u>11</u> p.m. <u>11</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town)</b> <u>Easton</u> (County) <u>Talbot</u> (State) <u>Md</u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>11-13-61</u> <b>19</b> <u>11:13 AM</u> <b>to</b> <u>11-13-61</u> <b>19</b> <u>11:13 AM</u> <b>that (I) (we) last saw the deceased alive on</b> <u>11-13-61</u> <b>and that death occurred</b> <u>11-13-61</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>E. C. H. Schmidt</u> M.D. <b>22b. DATE</b> <u>11/13/61</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>E. C. H. Schmidt</u> <b>22d. ADDRESS</b> <u>Easton, Maryland</u>				<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>11-13-61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Upper Burial</u> <b>23d. LOCATION</b> (City, town, or county) <u>New Upper Md.</u> (State) <u>Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Maurice E. Neumann &amp; Son, Inc., Md</u> ADDRESS <u>Easton, Md</u> <b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Kline</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u> <b>DATE</b> <u>JAN 16 '61</u>							

MEDICAL CERTIFICATION



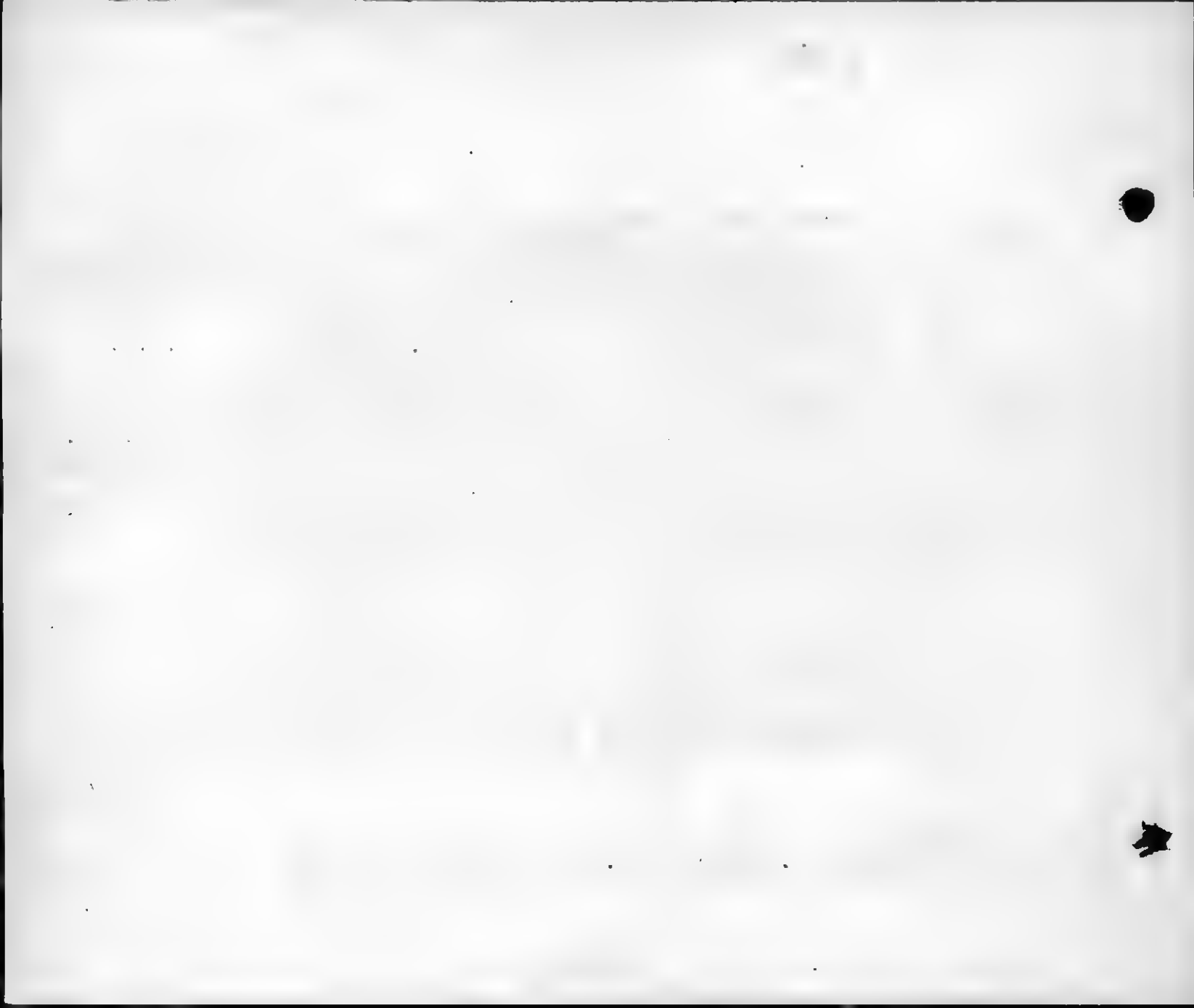


TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
C1104

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u>					
c. LENGTH OF STAY IN 1b <u>4 da</u>				d. STREET ADDRESS <u>None</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Wickler</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>8</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1891</u>			
9. AGE (In years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Lewis Wickler</u>				14. MOTHER'S MAIDEN NAME <u>Marie ?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>209-12-7792</u>					
17. INFORMANT <u>Katherine Wickler Greensboro, Md.</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>									
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert W. Trever</u>				22b. ADDRESS <u>Easton, Maryland</u>					
22c. PHYSICIAN'S NAME (Type) <u>Robert w. Trever</u>				22d. ADDRESS <u>Easton, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-11-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		23d. LOCATION (City, town, or county) (State) <u>Greensboro, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais</u>				25a. REC'D BY REGISTRAR <u>JAN 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1179  
CERTIFICATE OF DEATH

61165

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>3 Hours-</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joshua</i> Middle <i>Wilkens</i> Last <i>Wilkens</i>		4. DATE OF DEATH Month <i>January</i> Day <i>28</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-25-93</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm helper</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>220-32937</i>	
17. INFORMANT <i>Mrs. Mildred Realy</i> Address <i>Easton, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CHRONIC GENERALIZED ARTERIOSCLEROSIS</i> <i>450.0</i> DUE TO (b) <i>MALNUTRITION</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>450.0</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>450.0</i> INTERVAL BETWEEN ONSET AND DEATH <i>YRS.</i> <i>YRS.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <i>this hospital</i> ) attended the deceased from <i>1-27-</i> 1961, to <i>Jan. 28</i> , 1961, that (I) ( <del>we</del> ) last saw the deceased alive on <i>1-28-</i> 1961, and that death occurred <i>12:00</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Donald F. Bartley</i>		22b. DATE SIGNED <i>1-30-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Donald F. Bartley M.D.</i>		22d. ADDRESS <i>EASTON, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-31-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Richards Cem</i>		23d. LOCATION (City, town, or county) (State) <i>Easton Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>James S. Roswell</i> ADDRESS <i>Easton, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 1 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoma</i>	

1917

TO THE  
HONORABLE  
COMMISSIONER OF HEALTH  
STATE OF NEW YORK  
ALBANY, N. Y.

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above subject.

The Bureau of Public Health, Division of Veterinary Medicine, is pleased to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,  
J. H. [Signature]

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

61166

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie S Williams</u>				4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-79</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George FREE</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Lockman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Sittleton Grace, Sherwood, Md.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 421.4 DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>Hypertension, Paralytic</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u> <u>25 yrs</u> <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 2</u> 19 <u>66</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>GUY M REESER Sr</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>GUY M REESER Sr</u>				22d. ADDRESS <u>TILGHMAN Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>1-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cem.</u>	
23d. LOCATION (City, town, or county) (State) <u>Sherwood Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Dashiell, Canton, Md.</u>				ADDRESS <u></u>		25a. REC'D BY REGISTRAR <u></u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>				DATE <u>JAN 16 '61</u>			

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